STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

TENNESSEE BOARD OF MEDICAL EXAMINERS
COMMITTEE FOR CLINICAL PERFUSIONISTS
(800) 778-4123, ext. 532-4384 or Local (615) 532-3202, ext. 532-4384
www.tennessee.gov

APPLICATION INSTRUCTIONS FOR LICENSURE AS A CLINICAL PERFUSIONIST
APPLICATION CHECK SHEET

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Tennessee license to practice. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Committee.**

Licensure by Examination:	**Done**
1. Complete, sign, have notarized and mail the application pages 1 through 6.	_____
2. Attach to the application a clear, recognizable, recently taken passport size photograph of yourself.	_____
3. Request that a graduate transcript from a perfusion education program, the educational standards of which have been established by the ACPE and approved by CAHEA or its successor, be submitted directly from the educational institution to the Administrative Office. The transcript must show the program has been successfully completed and carry the official seal of the institution. Complete and mail Attachment 1 to your graduate school.	_____
4. If you are or have ever been licensed, certified, registered, or permitted by any state or country to practice as a Perfusionist or other health professional, you must complete and mail Attachment 1 to each and every state. Copies of Attachment 1 may be duplicated to accommodate each request.	_____
5. Submit two (2) original letters of recommendation from medical professionals who can attest to your character as a Perfusionist. These letters must be written within the preceding 12 months, identify the individuals as medical professionals, and **must be originals** on the signator's letterhead.	_____
6. Attach to the application a check or money order in the amount of $360 made payable to the Committee for Clinical Perfusionists.	_____
7. Cause to be submitted directly from ABCP proof of successfully completing the ABCP examination. See Attachment 2.	_____
8. Criminal Background Check. For instructions to obtain a criminal background check, go to http://tn.gov/health/article/CBC-instructions.	_____
9. Complete Attachment 5 – Declaration of Citizenship.	_____

Licensure by Grandfather Clause **Done**

Any person who is currently actively practicing perfusion is eligible to receive a license as a clinical perfusionist upon further showing satisfactory proof of the existence on, January 1, 2000, of all of the following requirements:

1. Cause to be submitted to the Administrative Office items 1 through 6, listed above except item number 3. Also do number 8 and 9. _____

2. Proof of four (4) years experience within the immediately preceding six (6) years (between January 1, 1994 and January 1, 2000) operating cardiopulmonary bypass systems during cardiac surgical cases in a licensed health care facility. Proof that the experience obtained in that four (4) year period was obtained while the person's primary functions in that health care facility was operation of the cardiopulmonary systems. Satisfactory proof shall include written job descriptions from employing facilities that cover the entire four (4) year period and letters from each of the following officials at the licensed health care facilities attesting to the fact that all requirements have been met:

   (a) a cardiac surgeon(s);
   (b) applicant's immediate supervisor(s), and
   (c) the chief of medical staff.

   All documents must be submitted directly from the employing facility or signatory to the Committee's Administrative Office. _____

Licensure by Reciprocity **Done**

To become licensed in Tennessee as a clinical perfusionist based on licensure or certification in another state, an applicant must:

1. Cause to be submitted to the Administrative Office all of items 1 through 6 except item number 3. Also do numbers 8, 9 and one of the following must also be submitted: _____

   (a) Be licensed or certified in another state that has licensure or certification requirements substantially equivalent, as determined by the committee, to the requirements of the Tennessee "Clinical Perfusionist Act" (T.C.A. 63-28-101 et. seq). Please submit a copy of the rules in place when licensure or certification was awarded and have submitted to the Administrative Office proof of a current, active clinical perfusionists license/certificate that is in good standing and without any restriction or encumbrance in another state. Submit Attachment 1 to all licensure/certifications that apply. _____

   (b) Cause to have submitted to the Administrative Office a current certificate as a certified clinical perfusionist issued by the ABCP. _____

Provisional License

A provisional license may be issued to an applicant who has applied for but has yet to take the licensure examination. To obtain a provisional license an applicant must cause to be submitted to the Administrative Office all of items 1 through 6, and items 8 and 9 above and submit attachment 2 to the ABCP National Office. Applicants must have made application to sit for the licensure exam and sign the ABCP verification release form (attachment 2) allowing ABCP to release all exam scores to the Tennessee Board of Medical Examiners. Additionally, holders of a provisional license must work under the supervision and control of a licensed clinical perfusionist at all times during which clinical perfusion is performed. Therefore, please have your supervising clinical perfusionist(s) fill out Attachment 4 and return it to the Committee's administrative office.

UNDERSTANDING THE APPLICATION PROCESS

If an address change occurs at any time, you must notify the Committee's administrative office, in writing, immediately.

1. All application fees and provisional licensure fees are non-refundable.

2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

Committee of Clinical Perfusionists 665 Mainstream Drive Nashville, TN 37243	For Federal Express or Special Courier: Committee of Clinical Perfusionists 665 Mainstream Drive Nashville, TN 37228

3. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you will be responsible for charges incurred. The Committee asks that you please give the administrative office every consideration in this matter.

4. If necessary documentation has not been received when your application has been received by the Committee's administrative office, an initial deficiency letter will be sent to you. The supporting documentation requested in the letter must be received in the Committee's administrative office sixty (60) days from the date of the initial deficiency letter. Files not completed within sixty (60) days will be closed.

5. Absent any complicating factors, the average application processing time is six weeks. Once the application is completed, your file will be promptly reviewed and an initial certification determination made. You will be promptly notified by letter of the initial determination and if your application is approved you will be able to view certification approval on the Internet at http://tennessee.gov/health/.

6. It is recommended that you do not make arrangements to accept employment as a Clinical Perfusionist in Tennessee until you are granted a license by the Committee of Clinical Perfusionist.

Thank you for your cooperation. We will make every effort to expedite your application in an efficient manner.

IMPORTANT: You must have a Tennessee license issued by the Committee of Clinical Perfusionists in your possession before you may lawfully practice.

ATTACH A CURRENT FULL-FACE PHOTOGRAPH

FOR OFFICIAL USE ONLY

2984-001 $350.00
2984-006 $ 10.00

STATE OF TENNESSEE
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APPLICATION FOR LICENSED CLINICAL PERFUSIONIST

Please **check** the appropriate category for which you are applying:

☐License by Exam ☐License by Grandfather Clause ☐License by Reciprocity ☐Provisional License

PERSONAL INFORMATION

PLEASE PRINT IN INK

Name: _____
Last First Middle Maiden

Social Security Number: ____ - ____ - ____ Date of Birth: _____

Mailing Address _____

_____

_____

_____ Zip

Phone: Home: (____) _____ Office: (____) _____

Place of Birth: _____ Sex: (optional, for statistical purposes only)
Female _____
U.S. Citizen: Yes ___ No ___ Male _____

Email Address: _____

Do you wish to receive notification, including renewal notification, from the Department of Health via email? Y N

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond high school. Use the back of this page if you need additional space. (Send Attachment 4 to the educational institution where you completed your program.)

From: ________ To: ________ ______________________________ ____________________
Mo/Yr Mo/Yr Educational Institution Location

From: ________ To: ________ ______________________________ ____________________
Mo/Yr Mo/Yr Educational Institution Location

From: ________ To: ________ ______________________________ ____________________
Mo/Yr Mo/Yr Educational Institution Location

From: ________ To: ________ ______________________________ ____________________
Mo/Yr Mo/Yr Educational Institution Location

Please complete your entire employment history starting with the most current position first. Use the back of this page if you need additional space.

DATES		LOCATION		POSITION AND DUTIES
From: ________ Mo/Yr	To: ________ Mo/Yr	________ (City)	(State)	________
From: ________ Mo/Yr	To: ________ Mo/Yr	________ (City)	(State)	________
From: ________ Mo/Yr	To: ________ Mo/Yr	________ (City)	(State)	________
From: ________ Mo/Yr	To: ________ Mo/Yr	________ (City)	(State)	________
From: ________ Mo/Yr	To: ________ Mo/Yr	________ (City)	(State)	________
From: ________ Mo/Yr	To: ________ Mo/Yr	________ (City)	(State)	________
From: ________ Mo/Yr	To: ________ Mo/Yr	________ (City)	(State)	________
From: ________ Mo/Yr	To: ________ Mo/Yr	________ (City)	(State)	________

LICENSURE INFORMATION

List below all states, countries or provinces in which you have ever been or currently are licensed, permitted or certified. Submit a copy of **Attachment 1** to all such states, countries, or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

List below **ALL** states, countries or provinces in which you hold or have ever held a license, certification or permit as a health professional other than perfusionist. Submit a copy of **Attachment 1** to all such states, countries or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative,** attach an explanation on a separate sheet. ***In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application*.**

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:

   a. The cognitive capacity to exercise reasoned professional judgments and to learn and keep abreast of developments in your profession; and

   b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devises, such as voice amplifiers; and

   c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. **"Medical condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV, tuberculosis, drug addiction and alcoholism.

3. **"Chemical substances"** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee, or within the past two (2) years.

5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS	**YES**	**NO**
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?	____	____
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?	____	____
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice?	____	____

[IF you receive such ongoing treatment or participate in such a monitoring program, the Committee will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.]

COMPETENCY INFORMATION continued

		YES	NO
2.	Do you currently use chemical substances?	____	____
	If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety?	____	____
	Please list: _____		
	_____		
3.	Are you currently engaged in the illegal use of controlled substances?	____	____
	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	____	____
4.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	____	____
5.	If you have ever held or applied for a license or certificate to practice as a Perfusionist in any state, country or province, has it been or was it ever denied, reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?	____	____
6.	If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited or otherwise disciplined or voluntarily surrendered under threat of restriction or disciplinary action?	____	____
7.	Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	____	____
8.	Have you ever been rejected or censured by a professional society?	____	____
9.	In relation to the performance of your professional services in any profession:		
	a. Have you ever had a final judgment rendered <u>against</u> you; or	____	____
	b. Have you ever had settlement of any legal action rendered <u>against</u> you; or	____	____
	c. Are there any legal actions pending <u>against</u> you or to which you are a party?	____	____
10.	If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?	____	____

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____, of _____,
(Applicant's Name) *(City)* *(State)*
being duly sworn and identified as the person referred to in this application and signed photos, attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the rules and regulations which were enclosed in the application packet and agree to abide by them in the practice of my profession in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary which may include an interview.

RELEASE to the Committee and Board, its staff and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice my profession.

AUTHORIZE the Committee and Board, its staff and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and any other qualifications;

RELEASE from liability the Committee and Board, its staff and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character and other qualifications for licensure.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

AUTHORIZE the American Board of Cardiovascular Perfusion National Office to release my exam scores directly to the State Board of Medical Examiners' Committee for Clinical Perfusionists.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE **DATE**

Sworn to before me, this _____ day of _____, _____.

_____
NOTARY PUBLIC

Affix Seal Here

My Commission expires _____

ATTACHMENT 1

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

COMMITTEE FOR CLINICAL PERFUSIONISTS
(800) 778-4123, ext. 532-4384 or Local (615) 532-3202, ext. 532-4384
www.tennessee.gov

CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one form to the licensure board in EACH state where you **hold or have ever held** a license to practice any profession. (Copies of this form can be used). **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

To Be Completed By Applicant (Please Print In Ink)

I, the undersigned applicant, was granted a **(circle one)** license or certificate to practice _____
(Profession)
numbered _____ on _____ in the State of _____.
(Date)
The Committee of Clinical Perfusionists of Tennessee requests that I submit evidence of the current status of that license in your state.

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Committee of Clinical Perfusionists.

_____
Applicant's Signature

Date _____

_____
Applicant's typed or printed name

To Be Completed By Administrative Office of State Licensure Board

Name In Full As it Appears On License/Certificate or Permit:

_____
(First) (M.I.) (Last)

License/Certificate/Permit Number: _____ Profession: _____

Date Issued: _____ Expiration Date: _____

Basis of Issuance: _____ Endorsement/Reciprocity with _____
(Check One) (State)
_____ Written Examination _____

Is the license currently active and registered? Yes ____ No ____
Is there any derogatory information on file? Yes ____ No ____ If yes, please attach supporting documentation.

_____ _____ _____
Authorized Signature Title Date

Please mail directly to: Committee for Clinical Perfusionists
665 Mainstream Drive
Nashville, TN 37243

ATTACHMENT 2

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

COMMITTEE FOR CLINICAL PERFUSIONISTS
(800) 778-4123, ext. 532-4384 or Local (615) 532-3202, ext. 532-4384
www.tennessee.gov

ABCP VERIFICATION

Please complete this form and mail it to the address below:

Send to:

American Board of Cardiovascular
Perfusion National Office
207 N. 25th Avenue
Hattiesburg, MS 39401

To Be Completed By Applicant (Please Print In Ink)

Dear ABCP Official:

I am applying for a license to practice as a Clinical Perfusionist in the State of Tennessee. By signing this document I authorize the American Board of Cardiovascular Perfusion National Office to release my exam scores directly to the State Board of Medical Examiners' Committee for Clinical Perfusionists.

Applicant's Name: _____
(First) (Middle) (Last)

Social Security No.: ____ - ____ - ____ _____
Signature for Release of Information

PLEASE MAIL SCORES DIRECTLY TO:

Committee for Clinical Perfusionists
665 Mainstream Drive
Nashville, TN 37243

ATTACHMENT 3

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

COMMITTEE FOR CLINICAL PERFUSIONISTS
(800) 778-4123, ext. 532-4384 OR (615) 532-3202, ext. 532-4384
www.tennessee.gov

TRANSCRIPT REQUEST

APPLICANT: supply the information requested in this box and then mail this entire form to your graduate school.

Full Name: _____
(Last) (First) (Middle/Maiden)

Address: _____ Social Security Number: ___ - ___ - ___

_____

_____

_____

Student Identification Number: _____

Year of Graduation: _____

Degree Obtained: _____

TO WHOM IT MAY CONCERN:

I am applying for a license to practice as a clinical perfusionist in the State of Tennessee. Please forward an original graduate transcript bearing the institution's official seal to:

Tennessee Board of Medical Examiners
Committee for Clinical Perfusionist
665 Mainstream Drive
Nashville, TN 37243

Thank you for cooperation and prompt response.

_____ _____
Applicant's Signature Date

ATTACHMENT 4 Applicant's Name _____

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

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SUPERVISING LICENSED CLINICAL PERFUSIONIST

This section must be completed by the supervising clinical perfusionist(s).
(This page may be duplicated if necessary)

List all practice settings:

1) Setting:

_____
Supervising Clinical Perfusionist

_____
Printed Name

_____
Address

_____
Tennessee License Number

2) Setting:

_____
Supervising Clinical Perfusionist

_____
Printed Name

_____
Address

_____
Tennessee License Number

3) Setting:

_____
Supervising Clinical Perfusionist

_____
Printed Name

_____
Address

_____
Tennessee License Number

4) Setting:

_____
Supervising Clinical Perfusionist

_____
Printed Name

_____
Address

_____
Tennessee License Number

ATTACHMENT 5

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

DECLARATION OF CITIZENSHIP
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that *every* ***adult* applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.**

I am a(n) _____ _____.
Healthcare Profession (Please Print) License number if applicable

Please Print Legibly

1. Name:_____
   Last First Middle Maiden_
2. Mailing Address: _____
   _
3. Phone Number: Home: (____)_____-_____ Office: (____)_____-_____ Fax: (____)___-_____
4. I am a United States Citizen: ____Yes ____No
5. I am a foreign national not physically present in the United States _____Yes _____No. If you answered yes, to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.
6. Applicants Claiming United States Citizenship **MUST** provide one of the following:
   a) Tennessee Driver's License, or photo ID issued by Department of Safety.
   b) A valid driver license or ID issued by another state, provided its issuance requirements meet Department of Safety criteria.
   c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
   d) A federally issued birth certificate.
   e) A valid, unexpired U.S. passport.
   f) A report of birth abroad of a U.S. citizen.
   g) A certificate of citizenship.
   h) A certificate of naturalization.
   i) A U.S. citizen ID card.
   j) Any successor document to #'s a-i above.
   k) SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.
7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)
   a) Permanent Residents

b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).
c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
d) Refugees who meet the qualifications set out in 8 U.S.C. 1157
e) Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
h) An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or "Green Card")

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status– "student visa")

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this _____ day of _____, 20__.

_____
Signature

Sworn to before me this _____day of _____, 20__.

_____ AFFIX SEAL HERE
NOTARY PUBLIC

My Commission Expires:_____

If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.